

Bureau Talk

February 2013

Bureau of Home Care and Rehabilitative Standards

Missouri Department of Health and Senior Services

<http://health.mo.gov/safety/homecare/>



Many changes have occurred in the Bureau of Home Care and Rehabilitative Standards since the last *Bureau Talk*.

On Dec. 31, 2012, the bureau said goodbye to co-worker and friend, Bonnie Quick, a health facilities nursing consultant. Bonnie logged 19 years as a state surveyor and 14 ½ as a bureau surveyor. Though her primary coverage area was Jefferson City to Kirksville, she surveyed all over Missouri. We will miss Bonnie's expertise, wit and charm. Please join the bureau in wishing her the best in retirement!

The bureau also said goodbye to Randi Sherrell, senior office support assistant, and Debbie Green, administrative office support assistant. Randi and Debbie pursued and accepted promotional positions. They, too, will be missed.

New faces also joined our team in December. Vickie Heuett, from Cameron, Mo., brings eight years of long-term care surveyor experience, and home health and hospice experience. Please join us in welcoming Vickie!

Last, but not least, the bureau welcomes back David Atkinson, administrative office support assistant, and Suzi Hamlet, health facilities nursing consultant. David and Suzi returned to their old positions and have settled in!

December also saw Director Margaret Donnelly leave the Department of Health and Senior Services. Gail Vasterling is the acting department director, and Jeanne Serra now serves as acting director for the Division of Regulation and Licensure.

Federal Year 2013 Survey Schedule



The final FY 2013 Mission and Priority Document for Survey and Certification was published on 11/21/2012. The state is required to complete all Tier 1 and 2 work.

For home health, Tier 1 assures no more than a 36.9-month lapse between surveys for any particular agency. Tier 2 includes an additional 5 percent targeted sample, which means states will survey 5 percent of the non-deemed home health agencies, selected from a CMS list that identifies agencies most at risk of providing poor care. There is no Tier 3 work for home health.

For hospice, there is no Tier 1 work. Tier 2 work for non-deemed hospice agencies is a 5 percent targeted survey; that is, each year, the state will survey 5 percent of hospices. For Missouri, 5 percent of hospices means five Tier-2 surveys. Tier 3 ensures no more than a 6.5-year lapse between surveys for any one particular provider.

Home Health Agency Abbreviated Survey Protocol

At the last federal "Basic Home Health Surveyor Training," CMS provided attendees with a tool to understand the new home-health survey process. See **Attachment A**.

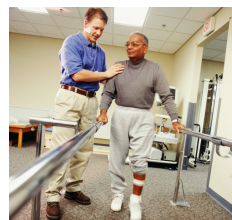


Missouri Case Law

Agencies ask where to get more copies of, *A Brief Summary: Missouri Law Regarding a Patient's Right to Make Health Care Treatment Decisions*. Agencies can call the Missouri Long-Term Care

Ombudsman Program at 800-309-3282, or print a brochure copy at

<http://health.mo.gov/seniors/ombudsman/publications.php>.



Therapy Goal Templates

A north Kansas City hospital's home-health agency gave bureau surveyors an in-service on physical, occupational and speech therapy goals.

The agency gave the bureau

permission to share templates from that in-service. See **Attachment B**.

Expansion Requests

The bureau has recently updated its policy on expansion requests.



New home health agencies or hospices must be operational for at least three years, or have had a full Medicare or state licensure survey, before expansion to additional counties will be considered.

For a requested expansion to be approved, the following must be met:

- An agency must be in compliance with the Medicare Conditions of Participation and state regulations.
- An agency must not have any pending complaint investigations.
- At CMS' recommendation, an agency cannot expand from one metropolitan or micropolitan statistical area to another. For a map of the Missouri metropolitan and micropolitan statistical areas, go to <http://www.missourieconomy.org/indicators/population/msa-2003.stm> (If an agency's expansion request into another statistical area were approved prior to the bureau's policy change, the agency will be allowed to keep the service area. However, no further expansion in that statistical area will be considered.) *(Continued on right)*

- The requested counties must be contiguous (touching) counties in an already approved service area.
- Home Health – If a requested area crosses a state line, the bureau must have written approval from the bordering state (Kansas, Nebraska, Iowa, or Illinois).
- Home Health – An agency must submit a CMS 855A form to its fiscal intermediary, but the state can approve an expansion without prior 855A approval.
- Hospice – Expansion across state lines is not allowed.
- Hospice – Per 19 CSR 30-35.010(1) (H) 3, an agency must be able to respond to emergent calls in the requested area within one hour after the need is identified.

After approval of a geographic territory expansion, or a branch or multiple location, further expansion requests will not be considered for at least one (1) year. An agency may not request a county expansion, and a branch or multiple location, simultaneously.

Home health agencies or hospices that have undergone a Change of Ownership must wait one (1) year before an expansion request will be considered.

Effective August 2010, the bureau will not, under any circumstances, approve temporary expansion of geographic territory for home health agencies or hospices.

Home Health

Vital Signs

The Missouri Board of Occupational Therapy recently said this about occupational therapists taking vital signs: "Occupational therapists are taught about assessing the stability of a patient prior to treatment to ensure safety. That being said, each agency should have a standard protocol addressing such matters for their licensed practitioners."

Licensed Practical Nurse and Orders

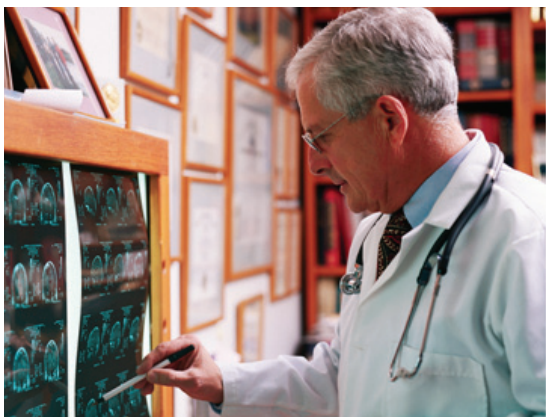
CMS recently clarified that all licensed practical nurse orders must be co-signed by a registered nurse. Per 484.18(c), "Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist" (as defined in 484.4 of this chapter). The RN is responsible for furnishing or supervising the ordered services.

An LPN may be on call; however, if a new order or a change in the plan occurs, an RN must be on back-up call to consult with the LPN.



Physician Orders

Per CMS, medical residents and interns are physicians. If they are licensed, they are allowed to give home health orders.



Based on a 4/27/2012 CMS rule, "Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements," medical residents and interns are also required to enroll as Medicare providers. Any question about this billing-related issue should be referred to an agency's Medicare Administrative Contractor or fiscal intermediary. A link to access the federal register follows: <http://1.usa.gov/11RjnOI>.

Hospice Issues

Nursing Shortage

A 9/14/12 CMS survey and certification memo (S&C 12-43) grants hospices more time to qualify for an “extraordinary circumstance” exemption. The exemption is for hospices who believe the nursing shortage has affected their ability to directly hire sufficient numbers of nurses. The policy’s effective date has been extended from Sept. 30, 2012, to Sept. 30, 2014. Please refer to S&C 12-43 for the specific criteria that must be met before an agency qualifies for this exemption.

Volunteers

A recent survey revealed that an Agency did not have enough volunteers to cover its service-area counties. CMS’ regional office was consulted. An agency must provide all of its patients, in all of its counties, access to a volunteer if a volunteer is needed.



One Hour Response Time

The bureau continues to get questions regarding the One Hour Response Time. The bureau expects hospices to assure that a nurse is available to respond to emergent patient needs within one hour of identification of that need. This expectation applies to all locations within a hospice’s service area, 24 hours a day.



The agency’s policy must define how this expectation will be accomplished. During a survey, the burden of proof will be on the hospice to assure compliance with 19 CSR 30-30.010 (1) (H) (3). Hospices whose nurses live in two separate ends of a service area must demonstrate that on-call and back-up coverage is sufficient. If a nurse who lives closest to the patient with an emergent need is not available to respond, another nurse must be available to respond within one hour.

The hospice’s policy must also address how the hospice will respond if one of its nurses arrives at a patient’s residence and determines the patient’s needs will be better met through a social worker’s or chaplain’s intervention. Agency policy should also clearly state the patient and caregiver’s role in defining emergent versus non-emergent need. If the patient or caregiver states that the need is emergent, it is.

Hospice 101

Two bureau surveyors, Bonnie Quick, RN, HFNC, and Judy Morris, RN, HFNC, presented at the Missouri Hospice and Palliative Care Association (MHPCA) Hospice 101 Conference in August in Columbia. Many who were unable to attend asked if the surveyors’ presentation were available. Please find it in **ATTACHMENT D**.

Hospice Issues



Electronic Medical Records

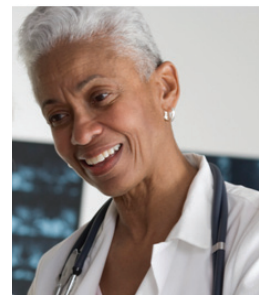
The Missouri Hospice and Palliative Care Association (MHPCA) conference prompted a question: With the increase in electronic medical records, are surveyors finding more problems when conducting surveys?

Agencies who remember the following will be more successful in filling out electronic medical records and meeting surveyor's needs.

- Focus on filling in all of the blanks. Surveyors are finding a lot of unanswered blanks.
- Use more narratives to explain what's going on. All systems allow free text. Use it to paint a picture.
- Use fewer "check marks." Surveyors are finding a lot of check marks and these do not tell a story.
- Other disciplines besides nursing must document thoroughly. Surveyors are finding documentation by a social worker or chaplain to be too generalized.

LPNs on Call

LPNs may take a call; however, if a new order or a change in the plan of care occurs, an RN must be on back-up call to consult with the LPN. Per 418.56(d) Review of the Plan of Care, "The hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days." Per M158 and ML159, "The plan shall be reviewed and updated by the interdisciplinary group at a minimum of every two weeks... Documentation on the plan of care shall reflect the changing needs of the patient/family, and the services required to meet those needs."



Per 418.56(a)(1), "The hospice must designate a registered nurse that is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care."

Keeping Current

As stated earlier, the bureau will complete only Tier-2 work for hospices. That means there may be only five hospices surveyed this federal fiscal year. State-license only surveys are not being conducted.

At the MHPCA conference, hospice agencies asked how to keep current since on-site surveys are infrequent. Here are several suggestions:

- On an annual or more frequent basis, review with staff the top 10 deficiencies cited nationwide.
- Read all *Bureau Talk* newsletters.
- Hold planned in-services throughout the year with staff to keep them informed and updated.

Hospice Issues

Office of Inspector General (OIG) Referrals

Some agencies feel it is unethical for nursing homes who own a hospice to require hospice-eligible residents to use that hospice. The bureau previously addressed this issue with the OIG.

Long-term care facilities can choose to contract with any hospice agency, or with only one. According to the OIG, this still gives residents a choice in choosing hospice services. How? The patient can choose to use their current nursing home's hospice or transfer to another facility that contracts with a different hospice. If a resident or patient needs assistance with this matter, it might be helpful to contact the Long-Term Care State Ombudsman at 573-526-0727.

However, it is unethical if the owner of a chain of nursing homes has contracts with multiple hospices, but instructs employees to refer facility residents to the company-owned hospice. In this instance, the nursing home resident is deprived of the right to choose a hospice. Agencies encountering this situation should call the OIG Inducement and Fraud Hotline at 1-800-HHS-TIPS.

The bureau also recommends a provider contact the OIG in the following situation. A private practice physician, who is also a part-time hospice medical director, refers patients to his or her hospice rather than letting patients choose one. Again, agencies encountering this situation should call the OIG Inducement and Fraud Hotline at 1-800-HHS-TIPS.

For more information on Medicare fraud and abuse, please see the Medicare Learning Network article, **(ATTACHMENT C)**. The article describes several of the Medicare fraud and abuse laws, such as the Anti-Kickback Statute, Stark Law, Criminal Health Care Fraud Statute, and Exclusions and Civil Monetary Penalties. It also lists resources and hotline numbers to report suspected fraud. More information is available at <http://www.cms.gov/Outreach-and-Education/Outreach-and-Education.html>.

Respite Care



The bureau recently received an inquiry as to whether a patient can go straight from inpatient hospice care to a facility for respite care. CGS, the MAC for hospices in Missouri, states there is no regulatory restriction that prevents a patient going from general inpatient to respite. However, the purpose of respite is caregiver relief, so documentation must support that need.

Hotline Changes

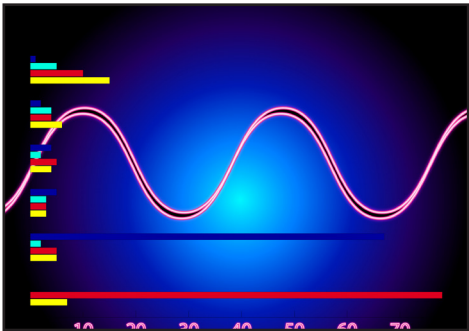


The Department of Health and Senior Services' Elder Abuse and Neglect Hotline hours have changed to 7 a.m. to midnight, 7 days a week. Individuals should call during those hours only. For life-threatening emergencies, they should call 911.



PPS Payment Rule

The new federal PPS Payment Rule titled, "Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2013, Hospice Quality Reporting Requirements, and Survey and Enforcement Requirements for Home Health Agencies," was finalized on 11/08/2012. The rule can be accessed at <http://1.usa.gov/WZ7QVv>.



Statistical Reports

By now, agencies should have completed their annual statistical reports. The reports, distributed to all home health and hospice agencies via Listserv, were due Jan. 31, 2013, via email.



Alternate forms of this publication for persons with disabilities may be obtained by contacting the Missouri Department of Health and Senior Services' Bureau of Home Care and Rehabilitative Standards, P.O. Box 570, Jefferson City, MO, 65102-0570, 573-751-6336. Hearing- and speech-impaired citizens can dial 711.

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